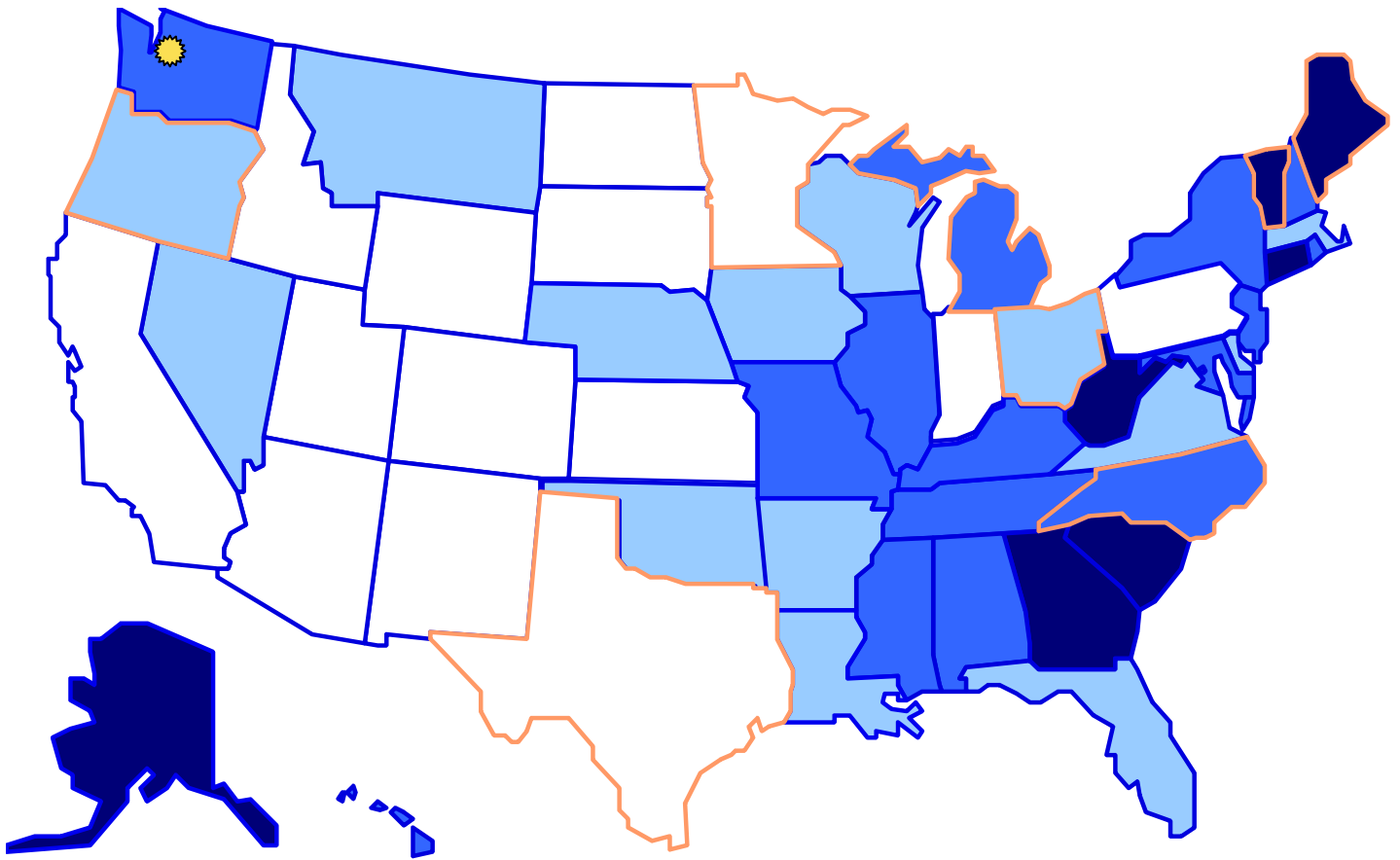


National CON Perspective and Experience

Selected Review of State Public Oversight Efforts



a presentation to the
Washington State CON Task Force
Wednesday, March 29, 2005, SeaTac Hilton

Selected Review of State Public Oversight Efforts

This table summarizes the findings detailed in the individual state profiles that are attached hereafter:

Name	CON	Hlth Png	Access	Costs	Quality	Other	Lessons
Maine	Yes Office of Elder Svcs., Dept. of Health and Human Svcs	Embedded in the Dirigo Health effort with resour. allocation limits; scope is very broad**	Dirigo Health focuses on increasing the number insured to all in 5 years	Limitation on CONs issued for nursing homes to not increase Medicaid costs	Quality Forum info on quality, performance, evidence-based medicine, and patient safety	Reform Act is coverage for all, pricing caps, limit expansions, rate regulation, watchdog group	A cooperative broad system of planning, regul., reporting, limits, insur. coverage is supportable.
Michigan	Yes Dept. of Community Health, Pol. & Legal Affairs*	Selected high-impact services CON reviewed, improvements after multiple studies, scope is mid-medium**	Implemented by combination of rigorous CON review criteria and insurer program efforts	Early reform efforts followed by automaker studies to illustrate CON Impact on cost	Mich. Quality Improvement Consortium set core guidelines and measures for insur. plans	Economic Alliance of Michigan and other business investments in quality and patient safety	Numerous studies of regulation, but cooperative interests prevail in health care
Minnesota	No	No evidence of health planning since end of health planning and regulation in 1985	MinnesotaCare and managed care health plans appear to cover most low income families	Moratorium established in 1984 to prevent new, expanded or relocated hospitals	Patient safety, consumer awareness and information, and medical group ratings are used	Required capital expenditure reporting and medical assoc. partnership developed	Emphasis on provider reporting and multi-faceted partnerships very successful
North Carolina	Yes Dept. of Health and Human Svcs., Div. of Facility Svcs.*	Comprehensive annually-updated health plan with a strong CON program; scope is high-medium**	CON helped with geographic access, and a broad array of providers assist with care	Reimbursement increases limited by Legislature, CON limited unneeded services	Hospital association started safety initiative for best practices and reporting	Batching of multiple CON applications has created competition within regulation	Strict adherence to traditional planning and regulatory values has positive impact
Ohio	Yes Dept. of Health, Bur of Diag. Safety & Personnel Cert.*	Extensive deregulation with focus on long term care; criteria is traditional; scope is low-limited**	Limited efforts, CON stresses service area analysis	Medicaid rates frozen, extensive examination of finances in CON applications	CON reviews staffing patterns, past performance and certification problems	Deregulation of acute care services resulted in explosion of new capacity; limited info	Often referenced as clearest example of negative impact of CON deregulation
Oregon	Yes Dept. of Health	Very limited staff regulating long term care and swing beds; scope is low-limited**	Priorities are referenced but little evidence of activity	State hospital association posts hospital charge data on Internet	Health Resources Commission assesses/reports impact of med. technology	Office of Rural Health coordinates health info, risk and efforts in rural areas	Limited focus on healthcare access, cost containment and quality
Texas	No	6-year State Health Plan by Statewide Health Coord. Council and Texas Dept. of State Hlth Svcs	County hospitals and clinics for indigent care with referral patterns, and 3 medical schools	Moratoriums for CMS and State reimbursement, and for building of nursing homes	Hospitals part of national 100,000 Lives Campaign and two major medical systems vie for quality	Coalition of contractors is Medicaid Claims Adm. and the Texas Health Network	Evidence of collaborative competition and cooperative private/public partnerships
Vermont	Yes Dept. of Banking, Ins, Sec. & Hlth, Div of Hlth Care Admin*	Reinvigorated reform efforts improved public accountability with Hlth. Res. Alloc Plan; scope very broad**	Hospitals are well-distributed geographically, with help across CT River from large med. ctr.	Emphasis on reducing cost of CON applications	Principles adapted from the Institute of Medicine aims (STEEEP)	Information Technology Leader group to establish plan by 2007	CON thru Plan which links philosophies, prevention and health info tech to improve care and contain costs

*location of CON in government

see attached **2005 Relative Scope and Review Thresholds

A Brief Review of Public Oversight Efforts in the State of Maine

I. Summary Observations and Lessons Learned

Maine has been a CON state since 1978, and has been studied by several legislative task forces, modified and changed, and recently significantly reformed. In 2003, “Dirigo” legislation was passed, and CON became part of a promising larger effort to control the costs of health care and to expand health insurance coverage to the uninsured.

II. Health Planning

Dirigo Health was established to arrange for comprehensive, affordable health care coverage to eligible small employers and individuals on a voluntary basis. Concurrently, a new state health planning law was enacted to develop a biennial state health plan, establish an annual statewide health expenditure budget report to set priorities in the plan and limit resource allocation under CON (called the “Capital Investment Fund”, or “CIF”).

Purpose and goals... The purposes of the Certificate of Need Act are to:

- Support effective health planning and quality health care that ensures access to cost-effective services;
- Ensure prudent use of State funds and reasonable health services choice while avoiding excessive duplication;
- Ensure public participation in the process of determining the array, distribution, quantity, quality and cost;
- Improve the availability of health care services and seek a balance between competition and regulation;
- Promote the development of primary and secondary preventive health care services.

More information available at: http://mainegov-images.informe.org/dhhs/beas/c_o_n/con_hcf_proc_man.pdf

General review criteria... Dirigo Health is required to make an annual determination of aggregate measurable cost savings, including savings attributable to CON. The State Health Plan provides CIF funding:

- Projects with the primary objective of eliminating threats to patient safety;
 - Projects that reflect a redirection of resources and focus on population-based health and prevention; and
 - Projects that demonstrate best practices in building construction, renovation and operation to minimize environmental impact both internally and externally (e.g. “green” energy).
- Very high priority is given to projects that reduce future demand, reduce operating costs for existing facilities, consolidate hospitals or services and do not contribute to sprawl, and telemedicine projects.

Scope of coverage... Maine is a highly-regulated state in terms of the breadth and scope of what is subject to review including transfer of ownership, acquisitions of major medical equipment, capital expenditures, new health services, changes in bed complement, and nursing facilities (see attached CON scope of services).

Service/facility specific policies... must be consistent with the State Health Plan and contribute to lower costs of care and greater efficiencies.

Monitoring efforts... efforts include cost and utilization reports for a period of one year following implementation of a service.

III. Access

Dirigo Health is intended to increase the number of insured in the State, and thereby reduce the amount of bad debt and charity care. It is intended to increase access to health care by the heretofore uninsured. The program is designed to make coverage available to every non-elderly uninsured individual in Maine within five years.

IV. Cost Containment

A moratorium on hospital projects started in 2004 and lifted in 2005. A state law imposing a limitation on CON for nursing homes prohibits the State from approving a CON that will add costs to the State’s Medicaid program.

V. Quality

The Maine Quality Forum was created to collect and disseminate research regarding health care quality, evidence-based medicine and patient safety to promote best practices. The Forum adopts measures to evaluate and compare health care quality and provider performance, and coordinates the collection of health care quality data in the State.

VI. Other

The Dirigo Health Reform Act strives for affordable coverage to all uninsured by 2009; voluntary hospital pricing caps; limit hospitals/doctors/insurers revenue increases; tighten medical facility expansions; impose rate regulation in the small group-insurance market; and establish a health-care quality watchdog group.

A Brief Review of Public Oversight Efforts in the State of Michigan

I. Summary Observations and Lessons Learned

Many in the Michigan business community, labor unions and hospitals support CON. Those who believe that traditional market supply and demand forces do not work in health care as in other aspects of the economy because consumers often pay but a fraction of the cost and don't have sufficient information to make decisions based on cost and quality support CON. Those who do believe that the health services market is like most others, generally oppose it. There is intense cooperative interest in all parts of health care improvement.

II. Health Planning

Purpose and goals... promote and assure the availability and accessibility of quality health services at a reasonable cost and within a reasonable geographic proximity for all people in this state, and appropriate differential consideration of the health care needs of residents in rural counties in ways that do not compromise the quality and affordability of health care services for those residents.

More information available at: http://www.michigan.gov/mdch/1,1607,7-132-2945_5106---,00.html

General review criteria... The overall approach in Michigan has not been to regulate the practice of medicine but to regulate the utilization of facilities and equipment and the location of services using a consistent measuring tool for each. Applicants are required to demonstrate that the service is needed, that it is not duplicative and that explorations have been made of the ways that the need can be met at the least cost.

Scope of coverage... select set of high-impact facilities and services (see attached CON scope of services).

Service/facility specific policies... at least ten factors shall be considered in CON review including applicability, definitions, community need, project delivery conditions, resource data, health service areas, financial feasibility, other considerations: other factors which may impact the acceptability of a proposal such as research, Medicaid participation, other performance provisions, project monitoring, and update frequency

Monitoring efforts... Upon a determination by the department that an applicant is not in compliance with the terms, conditions, or stipulations of an approved certificate of need, the department shall notify the applicant. The department shall make available, to the public, on request, a list of all certificates of need determined not to be in compliance with the terms, conditions, or stipulations approved in a certificate of need.

III. Access

The Criteria and Standards provide need methodologies for both urban and rural to assure access, quality, cost containment and many other factors. Health care access standards used by many insurers to improve programs.

IV. Cost Containment

Michigan incorporated medical cost containment measures into its 1985 reform package including a fee schedule and utilization review process, implemented in August 1989. Studies were also released in 2002 by Daimler Chrysler, Ford Motor Company and General Motors reporting that comparisons of their per capita costs state-by-state by all three companies found that their health care costs were lower in states with CON programs than in states without CON. All support CON in Michigan due to these cost savings.

V. Quality

The Michigan Quality Improvement Consortium was formed to establish and implement a core set of clinical practice guidelines and performance measures. The interventions designed and implemented by each plan to improve consistent delivery of services will be at the discretion of individual plans, but guidelines, performance goals, measurement methodology, and performance reporting will be standardized.

VI. Other

In 1982, The Economic Alliance for Michigan was founded to establish a forum for working together on those Michigan business and jobs issues on which they agree, including the effective previewing of CON applications. The Alliance focuses on cooperative, action-oriented endeavors to improve the reality and image of Michigan. In addition, the Michigan Health & Safety Coalition (MH&SC) is a collaborative quality improvement effort focused on improving health care quality in Michigan through cost-effective improvements in patient safety, including medical errors, across all health care settings.

A Brief Review of Public Oversight Efforts in the State of Minnesota

I. Summary Observations and Lessons Learned

Even though there is no formal regulation program, Minnesota has placed strong emphasis on assuring quality and affordable health care for its citizens. The state has been successful in developing partnerships to monitor access and quality, and disseminating information widely through Internet resources.

II. Health Planning

There is no evidence of health planning or any remnants of previous health planning efforts since formal certificate of need and state health planning and development efforts were discontinued in 1985.

III. Access

MinnesotaCare was established in 1992 to provide health care coverage to low-income people who do not have access to health coverage. By January 1997, all MinnesotaCare enrollees were converted to and continue to receive their services through managed care health plans.

IV. Cost Containment

A moratorium, originally established in 1984, was intended to expire in 1987; however, it is now permanent. It prevents establishment of new hospitals or any other activity that increases a hospital's bed capacity, relocates beds from one location to another, or otherwise results in an increase or redistribution of beds.

V. Quality

There are several organizations/websites which focus on improving the quality of health care in Minnesota, including:

- HealthFront promotes patient safety and consumer awareness about health care and offers a web-based (www.healthfront-info.org) satisfaction measurement tool;
- Minnesotahealthinfo.org established by the Governor's Health Cabinet, is designed to offer a wide range of information about the cost and quality of health care; one of the main categories of information on the site includes comparing cost and quality, assuring quality care, and buying health care;
- Minnesota Alliance for Patient Safety (MAPS) at www.mnpatientsafety.org. MAPS coordinates Minnesota's participation in the 100,000 Lives campaign, a national initiative to save 100,000 lives through improved safety by 2006;
- MN Community Measurement (www.mnhealthcare.org) rates medical groups on their care of patients; and
- The Leapfrog Group (www.leapfroggroup.org) publishes results of its hospital quality and safety survey.

VI. Other

There were a series of reforms passed between 1992 and 1994 which included capital expenditure reporting by providers and antitrust exceptions for providers and health plans. These antitrust exceptions allowed the Minnesota Department of Health to sanction agreements between providers or purchasers that might otherwise be construed as violations of state or federal antitrust laws. They were to be a substitution of regulation for competition.

The Minnesota Medical Association developed *Healthy Minnesota: A Partnership for Reform*, which includes leaders in health care, business, state government, labor, education, and consumer advocacy. The purpose of this partnership is to formulate and implement changes that will make the state's health care system more effective and affordable.

A Brief Review of Public Oversight Efforts in the State of North Carolina

I. Summary Observations and Lessons Learned

North Carolina has retained its long-standing system of regulating health care through its Medical Facilities Planning and Certificate of Need process. In fact, it has increased the facilities and services covered by Certificate of Need and broadened its impact to include all persons, not just licensed health care facilities. Most recently, it has added operating rooms and assisted living beds to the list of things requiring a CON. This, combined with the annual updating of the Plan, has been a successful model in addressing key issues.

II. Health Planning

Purpose and goals... The fundamental premise of the CON Law is that increasing health care costs may be controlled by governmental restrictions on the unnecessary duplication of medical facilities.

More information available at: <http://facility-services.state.nc.us/conpage.htm>

General review criteria... The development of the annual State Medical Facilities Plan is a key part of the regulatory process in North Carolina. The plan is developed by the 27-member North Carolina State Health Coordinating Council with the help of the Medical Facilities Planning staff. This Plan differs from similar documents in other states in one important respect: by state statute, the need determinations set out in the Plan become the “determinative limitations” on what may be approved for development through the CON process.

Scope of coverage... North Carolina Certificate of Need Law prohibits health care providers from acquiring, initiating, replacing, or adding to their facilities and equipment, except in specified circumstances, without the prior approval of the Department of Health and Human Services (see attached CON scope of services).

Service/facility specific policies... Basic principles governing CON are to promote cost-effective approaches, expand health care services to the medically underserved, and encourage quality health care services. The Department, in allocating its available resources, gives priority to health services that are considered to be cost-effective, and potentially beneficial to the majority of North Carolina's citizens.

Monitoring efforts... After the certificate is issued, the Department will monitor the development of the project through review of progress reports submitted by the applicant. The Department may withdraw a certificate if the holder of the certificate fails to develop and operate the service consistent with the representations made in the application or with any conditions placed on the certificate of need.

III. Access

The planning and CON process has done a good job of providing geographic access to all but the most complex services, and even those are available in reasonable proximity throughout the state. Economic access has been more challenging. Approximately 20% of the people are without health insurance, and while Medicaid coverage is excellent for those who qualify, the income qualification is quite low. Health care is provided to many of these persons by 24 Federally Qualified Health Centers, 81 State-Funded Rural Health Centers, 85 local health departments, 60 free health clinics, and private health care providers in the form of uncompensated care.

IV. Cost Containment

The General Assembly has limited Medicaid and other health care reimbursement increases to less than the rate of inflation in recent years. The need determinations have limited the development of specialty hospitals, free standing ambulatory surgical centers and diagnostic centers as well as acute care, psychiatric, nursing and assisted living beds; all of which have reduced health care costs.

V. Quality

The North Carolina Hospital Association has instituted a patient safety initiative that is part of the national “100,000 Lives Campaign” to reduce morbidity and mortality in health care through best practices and improved reporting systems.

VI. Other

In order for competitive applications to be reviewed at the same time, they have adopted a system to review applications according to a batched review schedule. Under this system, applications for similar services in the same geographic area are reviewed at the same time.

A Brief Review of Public Oversight Efforts in the State of Ohio

I. Summary Observations and Lessons Learned

Although limited in scope, the regulatory efforts in long-term care still engage some very useful general criteria. The deregulation efforts a decade ago dramatically reduced the jurisdiction of CON, and the ensuing explosion in capacity, particularly in physician-owned services, created considerable excess capacity and escalation costs.

II. Health Planning

Purpose and goals... The Certificate of Need Program ensures the public access to quality, long-term care services by requiring review and approval of activities involving long-term care beds.

More information available at: <http://www.odh.ohio.gov/odhprograms/dspc/certn/certneed1.aspx>

General Review Criteria

- Need for long-term care beds to provide care and treatment to persons having traumatic brain injuries;
- Impact on cost and quality of health services, and availability and accessibility of services;
- Advantages and disadvantages of alternatives, and impact on all other providers;
- Historical performance in complying with past CONs and in providing quality cost-effective health services;
- Short and long-term financial feasibility and cost effectiveness; and
- Relationship to the State Health Resources Plan, and participation in research.

Scope and coverage

- Establishment, replacement, renovation (over \$2,000,000), expansion, relocation or other change of a new long-term care facility, services or beds therein;
- Expenditure of more than 110% of the approved cost; and
- Any transfer of the CON prior to completion of the project (see attached CON scope of services).

Monitoring efforts

- Projects are monitored through development, completion, and licensure
- Required to maintain substantial accordance for 5 years after completion

III. Access

CON applications must:

- Identify primary and secondary service area with current and projected population;
- Provide current and projected patient origin data, including their special needs and circumstances; and
- Identify all providers within the service area.

IV. Cost Containment

- Medicaid rates were frozen for SFY 05-06
- Medicaid reimbursement formula is under transition to pay all providers the same rate
- CON applications must include operating statements for the past 2 years, current year, and first 3 years following the project; current costs and payment rates for other providers; historical performance of the applicant and related parties in providing cost-effective health care services evidenced by current costs and payment rates for other facilities under similar ownership; and ratio analysis of service population.

V. Quality

CON reviews project staffing requirements and availability, examine licensure survey findings, and prohibit the addition of long-term care beds to a facility with building code violations, a history of licensure revocation, or a pattern of certification violations.

VI. Other

In 1995 the Ohio General Assembly repealed Ohio's twenty year certificate of need program for all facilities, services, beds, capital, and equipment, except for long term care facilities which remain indefinitely subject to certificate of need review. The two main characteristics of this deregulated state are 1) a significant loss of inner city hospitals; and 2) a substantial increase in ambulatory surgery facilities and other freestanding facilities. We have no useable statistics on capital expenditures that have occurred during since deregulation. (See full report at <http://www.bricker.com/publications/articles/533.asp>).

A Brief Review of Public Oversight Efforts in the State of Oregon

I. Summary Observations and Lessons Learned

There is limited evidence available to adequately assess Oregon's public oversight efforts; however, it appears that there is limited focus on healthcare access, cost containment, and quality.

II. Health Planning

Purpose and goals... the achievement of reasonable access to quality health care, at a reasonable cost. Therefore, decisions regarding proposed new health services and facilities shall be made for reasons having to do with the most urgent community health needs in the various parts of the state. The director of health shall issue and annually review, and if necessary revise, a state health resources plan to include a description of the optimal quantity and distribution of all health services, facilities, and other resources, existing deficiencies in the health resources of this state, and excess health resources in this state.

More information available at: <http://egov.oregon.gov/DHS/ph/hsp/certneed/index.shtml>

General review criteria... includes determining whether there is a need for a new facility in the service area; were all alternatives considered; is there adequate staffing; will unnecessary be avoided; and what impact would the proposed project have on the cost of healthcare?

Scope of coverage... includes any new swing beds in a hospital or new skilled nursing or intermediate care service or facility (see attached CON scope of services).

Service/facility specific policies... each of the following criteria should be considered for CON review:

- The costs, methods and type of construction including energy conservation features, the current and projected zoning status of the project site, and space allocations and the configuration of existing and proposed areas;
- The relationship of the project to the most current edition of the "State Health Plan."
- The relationship of the project to the applicant's long-range plan and their planning process; and
- The need that the population served or proposed to be served has for the services to be provided.

Monitoring efforts... The director shall monitor the activities of persons granted certificates of need concerning long-term care beds during the period beginning with the granting of the certificate of need and ending five years after implementation of the activity for which the certificate was granted.

III. Access

The state gives priority to the achievement of reasonable access to quality health care at a reasonable cost. Established in 1985, the Oregon Health Action Campaign (OHAC) is a coalition of individuals and organizations who came together to empower the consumer voice in the development of quality, responsive health systems that allow all people to access the health care they need, when they need it from the providers of their choice at an affordable cost. It uses the Oregon Health Access Project as its research and education arm.

IV. Cost Containment

The Oregon Division of Health has a Health Systems Planning function whose mission is to strengthen the ability of Oregon's health system to serve Oregonians by improving access to primary care, reducing disparities in health care services, improving quality, patient safety, and the level of patient centered care. The state hospital association posts hospital charge data on their website so that health care consumers can compare their choices.

V. Quality

The Health Resources Commission conducts medical technology assessments, and evaluates the impact of capital expenditures for medical technology on the overall health care system. The state provides quality measures for 12 selected health care procedures and conditions statewide, such as heart bypass surgery.

VI. Other

The Office of Rural Health is mandated to coordinate statewide efforts for providing health care in rural areas and serve as a clearinghouse for information on health care delivery systems in rural areas. This office is to establish a risk assessment formula to identify the risk of a rural hospital to include the following categories: organizational, population, and economic.

A Review of Public Oversight Efforts in the State of Texas

I. Summary Observations and Lessons Learned

Although a regulatory implementation tool is missing, there is evidence of collaborative competition and cooperative private/public partnerships to address health care concerns.

II. Health Planning

There remains an active component of the former health planning infrastructure which expired in 1985:

- the Texas Statewide Health Coordinating Council (<http://www.dshs.state.tx.us/chs/shcc/default.shtm>).
- 17-member council which developed their 286-page 2005-2010 State Health Plan.
- broad purpose to ensure that health care services and facilities are available to all Texans.
- makes recommendations to the Governor and the Legislature through the Texas State Health Plan, which is submitted for adoption by November 1 of each even-numbered year.
- staffed by the Center for Health Statistics, with assistance from other program areas at the Texas Department of State Health Services.

2005 legislation also yielded additional health policy initiatives:

- The Texas Health Care Policy Council was established, comprised of 10 state agencies to respond to issues referred by the Governor, Lt. Governor, and House Speaker. Its charge is to include, facilitate and promote the use of technology as a way to decrease administrative costs, and increase and improve quality of health care; monitor, research and promote initiatives relating to patient safety and use of TeleMed and TeleHealth; and coordinate with other office and agencies primarily focused on the use of technology in health care.
- The Health and Human Services Commission's Office of Medical Technology was established to focus on improving Medicaid by evaluating new developments in medical technology and proposing implementing appropriate and cost effective measures in medical assistance programs.

III. Access

- County Hospitals for indigent care
- Clinics (formerly neighborhood clinics) for indigent care
- Hospital district staff these hospitals and clinics
- Referral patterns from clinics to hospital are established
- Medical Schools (3)

IV. Cost Containment

Moratoriums are in place for CMS and the State which have frozen reimbursement, and the State has stopped the building of nursing homes.

Specialty hospitals are a big concern; not only do they have to compete with the "two Big Bears of Medicine"—Texas Medical Center and SW Medical Center, they have the largest number of physician-owned limited-service hospitals in the nation at 57, with 28 more under development. More information available at: (<http://www.thaonline.org/Advocacy/PriorityIssues/LimitedServiceProvi0A54/index.asp>).

V. Quality

- Hospitals are part of the national "100,000 Lives Campaign" to reduce morbidity and mortality in health care through best practices and improved reporting systems.
- Medical Systems include Southwestern in Dallas, and Texas Medical Center –Houston,; these two "bear" systems, challenge each other for quality and cost.

VI. Other

As of January 1, 2004, a coalition of contractors headed by Affiliated Computer Services called the Texas Medicaid & Healthcare Partnership (TMHP) assumed Medicaid Claims Administrator duties for the State of Texas under contract with the Texas Health and Human Services Commission. TMHP also will administer the Texas Health Network, the state's Medicaid Managed Care Primary Case Management health plan. There are also concerns about the uninsured, particularly for those crossing the border from Mexico.

A Brief Review of Public Oversight Efforts in the State of Vermont

I. Summary Observations and Lessons Learned

After a 2003 reform effort, CON is rooted in a health resource allocation plan that is clearly and collaboratively linked to other state health planning philosophies, namely the chronic care initiative, a focus on preventive health care, and efforts to use health care information technology to improve care and contain costs. Additionally, the law added requirements that all hospitals conduct community needs assessments, issue annual community reports, and report on specified indicators of health care quality. Perhaps the main lesson learned was that the resources available to the regulators must meet the needs of the state for oversight and regulation.

II. Health Planning

Purpose and goals... assist in carrying out the policies of the state regarding health care delivery, cost and quality, by providing oversight of health care quality and expenditures through the certificate of need program and the unified health care budget for the state or with respect to Vermont residents, establishment and maintenance of consumer protection functions, and oversight of quality assurance within the health care system. More information available at: http://www.bishca.state.vt.us/HcaDiv/CON /CON_Main_Index.htm

General review criteria... the Health Resource Allocation Plan (HRAP) includes 23 CON standards that provide more detailed requirements that CON applications must be consistent with; an application may be approved if:

- the application is consistent with the HRAP and is designed serve the public good;
- the cost of the project is reasonable, the project will not result in an undue increase in the costs of medical care; and less expensive alternatives do not exist, would be unsatisfactory, or are not feasible or appropriate;
- there is an identifiable, existing, or reasonably anticipated need for the proposed project;
- the project will improve the quality of health care in the state, or provide greater access to health care, or both;
- the project will not have an undue adverse impact on any other existing services provided by the applicant; and
- if the application is for the purchase or lease of new health care information technology, it conforms with the health information technology plan, upon approval of the plan by the general assembly.

Scope of coverage... Extensive, primarily covering hospitals, non-hospitals, nursing homes, and home health agencies. Thresholds range from \$1.5m to \$3m for capital projects, and are set at \$1m for medical equipment and \$500,000 operating expenses for new programs or services (see attached CON scope of services).

Service/facility specific policies... The establishment of a home health agency requires a CON regardless of dollar thresholds.

Monitoring efforts... CONs now commonly have conditions that require detailed reporting for several months or years after the CON is granted, sometimes extending beyond the date the project is fully implemented. Also, the law now allows for significant personal as well as corporate fines and penalties for violations of the CON laws.

III. Access

Vermont's hospitals have developed with a geographic distribution that serves the population reasonably well and takes into account the rural nature of the state and the geographic challenges presented by the mountainous terrain. Also, 40% of Dartmouth Hitchcock Medical Center's patients in New Hampshire are Vermonters.

IV. Cost Containment

Most CON application reviews focus on cost containment inquiring about ways in which projects, particularly capital projects, can be done less expensively. When the HRAP is fully implemented, it may improve their ability to focus on cost containment.

V. Quality

Most CON applications focus on quality concerns. The HRAP is based on principles developed by the Institute of Medicine for an improved health care system including Safety, Timeliness, Effectiveness, Efficiency, Equity and Patient-Centeredness. This puts a clear focus on the quality factors in the IOM aims.

VI. Other

In 2003, the legislature issued a grant to a newly established organization, the Vermont Information Technology Leaders group, and charged it with recommending an health information technology plan for the state by 2007.

The CON Matrix of 2005 Relative Scope and Review Thresholds: CON Regulated Services by State

(this information is summarized from the 2005 National Directory of Health Planning, Policy and Regulatory Agencies, the 1998th edition published by the American Health Planning Association, also see map)

Rank (no. of svcs. x weight)	Categories	Count (no. of svcs.)																										compiled by Thomas R. Piper Missouri CON program Jefferson City, MO 573-751-6403	Reviewability/Thresholds								
		Acute Care	Air Ambulance	Armb Surg Ctr	Burn Care	Business Cntrts	Cardiac Cath	CT Scanners	Gamma Knives	Home Hlth	ICF/MR	Uthotlisy	Long Term Care	Med Off Bldg	Mobile Hl Tech	MRI Scans	Neonatal Care	Obstetric Svcs	Open Heart Svcs	Organ Transprt	PET Scans	Psychiatric Svcs	Rad Therapy	Renal Dialyis	Res Care Fac	Subacute	Substance Abuse		Swing Beds	Ultra-sound	Other (Items not covered)	Capital	Med Equip	New Svc	Weight		
																																3,000,000	1,000,000	500,000	0.9		
22.5 21.6	Vermont Maine																																				
18.4 14.4	North Carolina Michigan																																				
2.4 0.5	Oregon Ohio																																				

Disclaimer: Rank order relates to volume of items reviewed, NOT hierarchy of analysis or conclusions which are based on Criteria and Standards and decisions

Source: Updated January 19, 2005, using most recent information available